# THE DEVELOPMENTAL DISABILITIES PROFILE

## INSTRUCTIONS FOR COMPLETING THE DEVELOPMENTAL DISABILITIES PROFILE
### AND
### ADDENDUM FOR CHILDREN AGES 5 - 10

**Indiana Bureau of Developmental Disabilities Services**

**Revised February 11, 2001**

The Developmental Disabilities Profile (DDP) is an **informant-based** tool.  It can be administered with the individual, a reliable informant or with both.   Only one informant is necessary to complete the DDP.  The informant should be someone who best knows the individual.  If the individual has 24 hour paid staff, a staff person may be the most qualified informant that that individual.  In other cases, a parent or friend may be spending more time with the individual than anyone else.

If the individual or the informant is not reliable or capable of answering the questions, the administrator should seek another informant, if possible. If the informant cannot answer some of the questions or the administrator believes the informant is not reliable, the administrator of the DDP should examine collateral information.

If the collateral information does not contain an answer for some of the questions, the **administrator** must complete the remaining questions, based on their reasoned understanding of the individual's functioning.  **The computer systems in which the DDP will be completed will not score any DDP which has questions unanswered.**

**For children ages 11 – 17 and for adults, answer the individual component of all questions through page 7, leaving NONE blank**.  If the answer for a particular question is not known for certain, the person administering the DDP (or the informant) should answer the question, based on of his/her knowledge of the individual.  In these cases, the DDP allows for judgement in determining of the individual is capable of completing certain tasks.  For example, if an individual is bald, estimate his or her ability for hair grooming, based on that individual's functioning in other hygiene/grooming skills.

**For children ages 5 – 10, answer the individual components of all questions, including the children's addendum on page 8, leaving NONE blank**.  Children in this age group must have the original DDP and the children's addendum administered.  Again, if the answer for a particular question is not known for certain, the person administering the DDP (or the informant) should answer the question, based on of his/her knowledge of the individual.  In these cases, the DDP allows for judgement in determining of the individual is capable of completing certain tasks.

The DDP is not meant to be an all-encompassing picture of the individual.  Instead, it is a "snap shot" of what the individual is capable of at the time of the assessment.

# INFORMATION
## PAGES 1-3

1. **Social Security Number**
   Enter the individual's own nine digit social security number.

2. **Date of Birth**
   Enter the individual's 2-digit month, 2-digit day and four-digit year of birth.

3. **Last Name**
   Enter the last name of the individual.

4. **First Name**
   Enter the first name of the individual.

5. **Middle Initial**
   Enter the middle initial of the individual.

6. **Street Address**
   Enter the individual's street address.

7. **City**
   Enter the city in which the individual resides.

8. **State**
   Enter the 2 initials of the state in which the individual resides.

9. **Zip Code**
   Enter the 5-digit zip code in which the individual resides.  See attachment A.

10. **Phone Number**
    Enter the phone number (area code and seven digits number) for the individual.

11. **County of Residence**
    Enter the 2 digit county number in which the individual resides.

12. **Home County**
    Enter the 2 digit county number in which the individual initially resided.

13. **Medicaid ID Number**
    Enter the individual's Medicaid identification number.

14. **Gender**
    Check the appropriate box indicating the gender of the individual.

15. **Ethnicity**
    Check the appropriate box indicating the ethnicity of the individual.

16. **Residential Status**
    Check the appropriate box indicating the residential status of the individual.  If other, indicate the type.

17. **Vocational/Habilitation Programs**
    Check the type of program that the individual is involved in.  Up to three categories can be checked.  If other, indicate the type.

18. **Identified Developmental Disabilities**
    Circle "y" (yes) or "n" (no) indicating what best describes the individual's developmental disability.  More than one category can be checked.  Enter a description of any other developmental disability in #5, as needed.

19. **Primary Developmental Disability**
    Enter the number of the one developmental disability from number 18 that best identifies the individual's primary developmental disability.

20. **Type of Evaluation**
    Check the one type of evaluation that is being completed.

    INITIAL MCD ELIGIBLE: Initial evaluation, eligible for Medicaid (including Waivers) and funded by Medicaid.

    INITIAL NOT MCD ELIGIBLE: Initial evaluation, not eligible for Medicaid and state funded.

    PAS:  Pre-Admission Screening

    SIGNIFICANT CHANGE MCD: Need for an evaluation due to significant changes, eligible for Medicaid (including Waivers) and funded by Medicaid.

    SIGNIFICANT CHANGE State Funded: Need for an evaluation due to significant changes, not eligible for Medicaid and state funded.

    WAIVER ANNUAL EVALUATION: Annual evaluation for a waiver funded program.

    WAITING LIST LOC: Evaluation to determine applicability for waiver waiting list.

21. **Psychiatric Diagnosis**
    Enter the 5 digit DSM-IV Codes relating to the individual's psychiatric diagnosis, if applicable.

22. **Intellectual Assessment**
    Enter 1. the individual's valid IQ score, 2. the name of the test utilized, 3. the date of the test, and 4. the name of the person who administered the test.

23. **Hearing**

Check the category that best describes the hearing ability of the individual. This should be indicative of the individual's hearing with the use of hearing aids, as applicable. If an individual is deaf in one ear and has normal hearing in the other ear, a moderate loss would be indicated.

24. **Vision**

Check the category that best describes the vision of the individual. This should be indicative of the individual's vision with best correction. If an individual is blind in one eye and has normal vision in the other eye, a moderate impairment would be indicated.

**Guardian Information**

25. **Guardian Name**

Enter the last name, first name and middle initial of the guardian, leaving a space between each.

26. **Guardian Phone Number**

Enter the phone number of the individual's guardian.

**BDDS Service Coordinator Information**

27. **BDDS Service Coordinator Name**

Enter the last name and first name of the BDDS Service Coordinator, leaving a space between each.

28. **BDDS Service Coordinator Phone Number**

Enter the phone number for the BDDS Service Coordinator.

**Case Manager Information**

29. **Case Manager Number**

Enter the six-digit code associated with the Case Manager as identified through the Medicaid Waiver number. BDDS staff will be assigned numbers.

30. **Case Manager Name**

Enter the last name and first name of the Case Manager, leaving a space between each.

31. **Case Manager Phone Number**

Enter the phone number for the Case Manager.

32. **Has the person been the alleged perpetrator of any of the following crimes reported to a law enforcement agency during the last year?**
Circle "Y" (for yes) or "N" (for no) for each crime.

33. **Police involvement due to maladaptive behaviors?**
Circle "Yes" or "No."

34. **Client requires two or more staff on-site for any part of the day, for more than 30 days.**
Circle "Yes" or "No."

35. **If barriers to the person achieving opportunities for personal independence, productivity, integration and/or community inclusion have been identified, such barriers result primarily from which of the following?**
If any of the listed choices are limiting the individual's opportunities, rank the three most important in order of importance - with the most important barrier ranked number 1 and the least important of the barriers ranked number 3.  Write the number in the box to the left of the corresponding barrier.  If none of these are barriers for the individual, write "9"  next to "Other/None."

36. **If barriers to the person achieving his/her identified lifestyle and related needs have been identified, such barriers result primarily from which of the following?**
If any of the listed choices are preventing the individual from achieving his/her identified lifestyle and needs, rank the three most important in order of importance - with the most important barrier ranked number 1 and the least important of the barriers ranked number 3.  Write the number in the box to the left of the corresponding barrier.  If note of these are barriers for the individual, write "9" next to "Other/None."

37. **Significant medical conditions requiring specialized medical supports or that significantly interfere with participation in services?**
Circle "Yes" or "No."

38. **Indicate how often the individual has utilized or required any of these health-related services in the past year (Key A),  Over the past year, if any of these health related services have been needed, but not utilized, indicate the factor limiting/preventing those services (Key B).**
Answers for Key A and Key B are to the **right** of the question #38.  The numbers listed between Key A and Key B correspond with a particular answer in each Key.  Use the text list in each key to find the corresponding number then list only the number, not the text, as answers.

Use the list in "Key A – Frequency of Services" to describe the frequency a particular service has been utilized.  For example, if Primary Medicaid Care has been utilized occasionally in the last year, a "2" should be recorded in the Key A column next to Primary Medicaid Care.  Please use the choices in Key A to answer in the column labeled Key A next to each choice.

Use the list in "Key B – Factors Preventing Services" to describe the reasons why the individual has not been able to utilize needed medical services or why utilization has been limited.  For example, If the individual needed Primary Medicaid Care, but has not been able to utilize it due to the opinions or beliefs of the person's guardian, a "6" should be placed in the Key B column next to Primary Medicaid Care.  Please use the choices in Key B to answer in the column labeled Key B next to each choice.

# ASSESSMENT
# PAGE 4-7

ENTER THE SOCIAL SECURITY NUMBER AND NAME (LAST, FIRST AND MIDDLE INITIAL) OF THE INDIVIDUAL WHO IS BEING EVALUATED.

1a. **Primary Provider Agency**
Enter the name of the individual's primary service provider.

1b. **Assessment Date**
Enter the date in which the DDP assessment was completed. Enter the 2-digit month, 2-digit day and four-digit year.

1c. **Name of Informant**
Enter the name of the informant. To the right enter the informant's relationship to the individual e.g. mother, brother, residential staff etc.

2. **Preferred Language**
Check the box of the preferred method of communication used by and understood by the individual. If other, indicate the preferred mode.

3. **Medical Conditions**
Indicate by circling "y" (yes) if the individual actually has the condition at the present time. If the person is currently being screened or tested for one of the listed conditions, or does not have the condition, circle "n" (no) for that category.

4a. **Seizure History**
Indicate by circling "Yes (1)" if the individual has any history of seizure activity and proceed to questions 4b and 4c. Circle "No (2)" if the individual has no seizure history and skip to question 5a.

4b. **Type of Seizures**
Check all types of seizures the individual has experienced in the last twelve months. If the individual has not had any seizures in the last twelve months, check the first box – "No seizures this year" and go to 5a. If you know that the individual has had a seizure but are unsure of the type of seizure, check the last box – "Had some type of seizure – not sure of type", experienced in the last twelve months. Multiple checks may be supplied. Generalized – tonic-clonic (Grand Mal) seizures are often characterized by being incontinent.

4c. **Frequency of Seizures**
Check the one category, which indicates how frequently the individual has experienced seizures that involve loss of awareness and/or loss of consciousness in the last twelve months. If an individual's seizures are very episodic or cyclical in nature, report the frequency of the episodes over the last twelve months rather than the individual occurrences.

> Example: If a person has seizures several times a week, circle #5 for "Several times a week". However, if an individual is seizure free, yet has several seizures throughout one or two weeks during the year, treat this as episodic in nature and circle #2 for "Less than once a month".

5a. **Medications**
Circle "Yes (1)" if the individual is currently taking any prescription medication and "No (2)" if the individual is not currently taking prescription medication. If "No (2), proceed to question 6.

5b. **Prescribed Medication**
Circle "1" for any medications that the individual is not currently taking. Indicate by circling "2" if the individual is currently taking any of the identified medications. Medication should be restricted to maintenance medications given on an ongoing basis.

5c. **Injections**
Circle "yes (1)" if the individual is receiving ongoing medication by injection. Circle "No (2)" if the individual is not receiving ongoing medication by injection.

5d. **Medication Support**
Check the level of support the individual receives when taking prescription medication. Levels of support are defined as follows:

1. TOTAL SUPPORT: The staff or caregiver must physically administer medications by such means as injections, drops, mixed in food, or the individual is physically incapable of taking medications or is often resistive (spits out or refuses to swallow it).

2. ASSISTANCE: The staff or caregiver keeps the medication(s) and gives it (them) to the individual at the appropriate time for self-administration.

3. SUPERVISION: The individual keeps or takes his/her own medication, but the staff or caregiver may have to prompt or confirm that he/she has indeed taken it.

4. INDEPENDENT: The individual is totally responsible for his/her own medications.

> If the individual takes more than one medication and the support is provided at different levels, i.e. tablets and injections check the one that indicates more support. CHECK ONLY ONE RESPONSE.

6. **Medical Consequences**
This question relates to the programming consequences of an individual's medical condition. Consider all aspects of the individual's medical condition. Circle "y" (yes) or "n" (no), as applicable.

7. **Mobility**
   Check the one response that best describes the individual's typical level of mobility. Note that choice #2, "Walks independently, but with difficulty", involves walking unaided; choice #3, "Walks independently with corrective device", involves the use of a corrective device such as a cane or walker. Choice #4, "Walks only with assistance from another person", means that the individual needs some help from another person when walking. Include sensory deficits in your assessment if they are a significant impediment to mobility. If the individual is able to ambulate within their home, however unable to walk long distances without a wheelchair or other support, circle #3.

8a. **Wheelchair**
   Circle "Yes (1)" if the individual uses a wheelchair for any reason. If the individual does not use a wheelchair at all, circle "No (2)" and skip to question 9.

8b. **Wheelchair Mobility**
   Check the one answer that best describes the individual's wheelchair mobility. The wheelchair may be motorized.

9. **Motor Control**
   Circle "y" (yes) or "n" (no) for each item. Base your response primarily on personal knowledge and observation of the individual and only secondarily on the individual's records.

   | These questions should be viewed as whether or not the person is presently capable of doing these things. |
   | --- |

   It is suggested that the assessor use pins, blocks, or lifesavers to determine an individual's ability to pick up small objects. In most cases, these items should be tested directed. However, if you have not had the opportunity to observe the individual perform a particular task e.g. the item "Can cut with scissors along a straight line", estimate his/her ability to perform that task based on similar tasks you have observed the individual perform. Base your answers only on the individual's capabilities and not on his/her willingness or unwillingness to engage in these activities.

10. **Cognitive Ability**
   Circle "y" (yes) or "n" (no) for each item. This question attempts to determine cognitive abilities. The individual may have to be prompted verbally, but base your answers only on the individual's capabilities as in the previous question. For each of the items generalize his/her ability to other settings.

   | "Understand simple functional signs" – the individual should be able to recognize and understand exit signs or restroom signs whenever he or she encounters them. |
   | --- |

The ability to distinguish right from left can be determined by holding your own hands up and asking the individual to identify which is your right or left hand. The ability to do simple addition or subtraction can be determined of asking the individual to complete simple single digit samples. This might also be determined by asking the individual how many marbles he/she would have if they had seven and lost one. It is suggested that an individual's ability to tell time be evaluated by showing several "times" on sheets of paper. See Attachment B for examples that can be used in the assessment process.

11. **Communication**

Circle "y" (yes) or "n" (no) for each item. The mode of receptive and expressive communication skills can be written, verbal, sign, symbolic, or electronic.

The ability to understand a joke or story may be determined by telling a joke or story and then discussing this with the individual to determine their level of understanding. A simple example would be "Why did the chicken cross the road? To get to the other side!" The ability to tell a story or the plot of a television show might be determined by asking the individual what their favorite television show is and then asking what happened in the last episode. The ability to describe realistic plans in detail might be determined by asking the individual what their plans are for the next weekend.

12. **Behavior Frequency**

Restrict answers to behaviors observed, even if you are aware of problems exhibited by the person at other times and in other settings. Evaluate this based on the environment reflects the most behavioral problems or need for intervention. When trying to describe someone's behavior, carefully consider into which category a given behavior fits. Select the most appropriate category and do not count the same behaviors in several behavior categories. Base your rating on a single episode. Much of this information can be obtained from the individual's program plan and records reflecting current behaviors.

Circle the appropriate frequency for each of the items using the following code:

1. Not this year

2. Occasionally (less than once a month)

3. Monthly (About once a month)

4. Weekly (About once a week)

5. Frequently (Several times a week)

6. Daily (Once a day or more)

> If a person has tantrums several times a week, circle # 5 for "Frequently".
> However, if a person is usually calm yet has several emotional outbursts

> throughout one or two days during the month, threat this as episodic in nature and circle # 3 for "Monthly".

13. **Behavior Consequences**

Circle "y" (yes) or "n" (no) for each consequence of an individual's behavior.  Keep in mind the following guidelines.

Record behavior consequences only as you see them.

Respond based on what has happened as a result of any behavior on the part of the individual, not just those listed in previous questions.

This relates to only asking about the results of the individual's behavior.

"Environment" refers to program areas where an individual lives and works.  Chose the environment in which the individual has the most needs.  Some examples include locks on all doors to prevent the individual from leaving, requires a private room to avoid problems, or locked dressers to prevent stealing.  "Time-out" should be related to a formal behavior plan.

14. And 15. **Self Care and Daily Living Skills**

Circle the appropriate number (1-4) for each item.   We are interested here in how well the individual performs these activities as stated in each item from start to finish at a reasonably acceptable level.

1.  TOTAL SUPPORT: The individual is completely dependent of others to carry out activities on his/her behalf. Total support requires that the provider or caregiver be involved throughout the task. (Depending)

2.  ASSISTANCE: The individual often requires physical aid in order to accomplish tasks.  The service provider or caregiver would offer regular verbal prompting and instructions as well as regular physical hands-on aid. (Helping)

3.  SUPERVISION:  The individual is able to perform tasks with some verbal direction.  The individual usually understands the need for and is usually willing to perform a task.  (Reminding)

4.  INDEPENDENT:  The individual understands the need for, is willing to and can perform tasks with no prompting.  The individual may need supervision and/or assistance in exceptional circumstances.

Where the program does not really allow someone to perform a certain activity, we would like an estimate of the individual's ability to perform this task independently.  For example, if an individual is bald, evaluate their ability for hair grooming.

Putting on clothes relates to the individual's ability to put clothes on, not if they are capable of selecting appropriate clothes.

Feeding self refers to just being able to feed oneself once the food is on the table, not being able to cook or prepare food. If an individual feeds themselves with their hands, then they are independent in feeding. If the individual is able to feed themselves, however is very messy and perhaps losing weight, then they would need total support.

If an individual receives a pureed or ground diet because they have problems chewing, then #2 – assistance would be circled. If the individual needs help swallowing, circle #1 – total support.

In Daily Living Skills – managing money includes such activities as budget making and using bank services.

16. **Clinical Services**
Circle the appropriate number (1-6) for each item. Indicate only those services provided or funded by Medicaid or state funding.

Include direct service to the person or any supervision of that service by the clinical specialist. Also include services provided by other specialists or assistants under the direct and regular supervision of the clinical specialist listed. These other specialists and assistants include psychologist with master's degree, physical therapist assistant, occupational therapist assistant, licensed practical nurse (LPN), and social worker with a bachelor's degree. For item h, "Social Worker", include service given to immediate family members or guardian as service received by the individual.

If there was a brief break in an otherwise regular service due to a temporary inability to provide the service (for example, a clinician leaves and it takes a month or two to replace him/her), indicate the frequency with which the person was scheduled to receive the service.

Mark only one response on each row. In the case where there was only an assessment (by a physician, for instance) in the last year, circle #2, "Occasionally". Circle #1, "Not this year", for services not provided with Medicaid or state funding.

Do not mark services provided by other programs even though you may be aware of them.

17. **Assessment Completed by**
Enter the last name and first name of the individual completing the assessment.

18. **Phone Number**
Enter the phone number of the individual completing the assessment.

# INSTRUCTIONS FOR ADDENDUM TO THE DDP FOR CHILDREN AGES 5 – 10.

**Child's Name**:  Complete last name, then first name and middle initial.

19. Circle the number that best described the child's functioning for each question (1 – 10) using the Key on the left.

**Remember**:   The scoring scale is 1 – 4, with  "1" indicating that the child has no problems with that particular domain, while a "4" indicates a severe problem requiring intensive treatment efforts, much hands-on care and close supervision.

**Assessment Completed By**:  Enter the Last, then first, name of the individual who administered the assessment.

**Phone Number**:  Enter the phone number of the individual who administered the assessment.

**ATTACHMENT A**

County Numbers and Names

| | | | |
|---|---|---|---|
| 01 ADAMS | | 47 LAWRENCE | |
| 02 ALLEN | | 48 MADISON | |
| 03 BARTHOLOMEW | | 49 MARION | |
| 04 BENTON | | 50 MARSHALL | |
| 05 BLACKFORD | | 51 MARTIN | |
| 06 BOONE | | 52 MIAMI | |
| 07 BROWN | | 53 MONROE | |
| 08 CARROLL | | 54 MONTGOMERY | |
| 09 CASS | | 55 MORGAN | |
| 10 CLARK | | 56 NEWTON | |
| 11 CLAY | | 57 NOBLE | |
| 12 CLINTON | | 58 OHIO | |
| 13 CRAWFORD | | 59 ORANGE | |
| 14 DAVIESS | | 60 OWEN | |
| 15 DEARBORN | | 61 PARKE | |
| 16 DECATUR | | 62 PERRY | |
| 17 DEKALB | | 63 PIKE | |
| 18 DELAWARE | | 64 PORTER | |
| 19 DUBOIS | | 65 POSEY | |
| 20 ELKHART | | 66 PULASKI | |
| 21 FAYETTE | | 67 PUTNAM | |
| 22 FLOYD | | 68 RANDOLPH | |
| 23 FOUNTAIN | | 69 RIPLEY | |
| 24 FRANKLIN | | 70 RUSH | |
| 25 FULTON | | 71 ST. JOSEPH | |
| 26 GIBSON | | 72 SCOTT | |
| 27 GRANT | | 73 SHELBY | |
| 28 GREENE | | 74 SPENCER | |
| 29 HAMILTON | | 75 STARKE | |
| 30 HANCOCK | | 76 STEUBEN | |
| 31 HARRISON | | 77 SULLIVAN | |
| 32 HENDRICKS | | 78 SWITZERLAND | |
| 33 HENRY | | 79 TIPPECANOE | |
| 34 HOWARD | | 80 TIPTON | |
| 35 HUNTINGTON | | 81 UNION | |
| 36 JACKSON | | 82 VANDERBURGH | |
| 37 JASPER | | 83 VERMILLION | |
| 38 JAY | | 84 VIGO | |
| 39 JEFFERSON | | 85 WABASH | |
| 40 JENNINGS | | 86 WARREN | |
| 41 JOHNSON | | 87 WARRICK | |
| 42 KNOX | | 88 WASHINGTON | |
| 43 KOSCIUSKO | | 89 WAYNE | |
| 44 LAGRANGE | | 90 WELLS | |
| 45 LAKE | | 91 WHITE | |
| 46 LAPORTE | | 92 WHITLEY | |
| | | 97 OUT OF STATE | |